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Proposals for

Medicare-Medicaid Reform

and

Overall Hospital Revenues Limitation

Prepared by the Staff of the

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

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Public Laws, 96th Congress, 1st Session 1979

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A. Introduction

Basic elements

The legislation includes a national voluntary limit on the rate of increase in total hospital costs of 9.7 percent during calendar year 1979. That national voluntary limit is based on the President's hospital anti-inflation guideline for 1979.

If hospital expenses nationally increase more than the national voluntary limit, then standby mandatory controls would be "triggered in" effective January 1, 1980.

The controls would include a mandatory limit on inpatient revenues per admission for each hospital covered. The mandatory limit would have two components: the basic limit (the rate of increase in the hospital's market basket), and an efficiency/inefficiency allowance. The mandatory limit could be adjusted for special circumstances in specific hospitals.

Hospitals covered

All 6,000 community hospitals would be covered by the national voluntary limit on total expenditures. As discussed later, if the mandatory controls were triggered in, certain individual hospitals would be exempted from these controls.

B. Components of the National Voluntary Limit

A national voluntary limit for 1979 would be set based, like the President's voluntary hospital anti-inflation guidelines, on three components:

1. *An Inflation allowance.* The inflation allowance is set equal to the anticipated hospital market basket inflation.

The market basket inflation will be announced at the beginning of each year. If inflation is higher than expected, corresponding changes would be made in the inflation allowance and thus in the voluntary limit.

In 1979, market basket inflation is estimated to be 7.9 percent.

2. The second component is a population growth allowance. Population growth is estimated at 0.8 percent in 1979.

3. The third component is an allowance for new services of one percent. If the hospital industry can increase productivity or efficiency to offset the cost of new services then it will be able to expand services by more than one percent on average.

C. Exemptions

If the voluntary limit is not met during 1979, the mandatory controls will become effective on January 1, 1980. Some hospitals, however will be *exempt* from the mandatory controls. The exemption categories, the number of hospitals affected and the percent of total hospital expenditures affected based on 1977 data are listed below.

	Number	Percent of total	Percent of total hospital expenditures
Total community hospitals	5,776	100.0	100.0
Exempted from mandatory controls because the hospital:			
Is located in a State in which total hospital costs increased 9.7 percent or less	300	5.2	10.5
Is located in a State with an approved mandatory cost control program [1]	841	14.1	24.2
Had an increase in total hospital expenditures of 9.7 percent or less	1,929	32.3	30.3
Is a small nonmetropolitan hospital (4,000 admissions or less); is a new hospital (less than 3-yr old); or 75 percent of its patients are members of federally qualified HMOs	2,168	36.3	12.4

[1] An existing mandatory program would be exempt if it is within 1 percent of the State voluntary limit. Other State programs could be approved for exemption by meeting certain general conditions.

A given hospital may be exempt on more than one ground; i.e., it could be a small nonmetropolitan hospital in a State with a mandatory cost control program.

In aggregate, it is presently estimated that approximately 3,290 hospitals would be exempt from mandatory controls. These hospitals collectively represent 56.6 percent of total hospitals and 50.8 percent of total hospital expenditures.

D. Standby Mandatory Program

If the voluntary limit is not met nationally, mandatory controls would apply to all hospitals not otherwise exempt.

Individual hospitals under the mandatory program would be granted an allowable rate of increase in total inpatient revenue per admission. The mandatory limit has two components—the basic limit and an efficiency allowance—and they may be adjusted for special circumstances affecting particular hospitals.

1. The basic limit

Inflation allowance.—Each hospital would be permitted an increase on inpatient revenue per admission in calendar year 1980 equal to the actual increased costs in its own market basket. This allowance is based on:

weights derived from the individual hospital's cost components.

prices from national indices unless adequate local indices are available.

wages from local indices for supervisory workers and from the hospital's own average wage for nonsupervisory workers.

Rationale.—This approach tailors the basic limit to needs of the individual hospital, and assures that low-paid hospital workers will not bear the brunt of restraints.

Efficiency/inefficiency allowance.—Each hospital would also receive a bonus for efficiency or penalty for inefficiency. This efficiency/inefficiency allowance is then added to or subtracted from the hospital's inflation allowance in determining the hospital's basic limit on inpatient revenue per admission.

A hospital would be considered efficient if its *routine costs per day* are the same or lower than those of similar hopsitals.

Routine costs are "hotel-type" room and board services and nursing services.

Hospitals would be grouped according to bed size, urban-rural location, and possibly other factors to determine similarity.

Bonuses and penalties would be provided as shown below:

Standing relative to peer hospitals on routine costs per day:	*Bonus/penalty*
Less than 90 percent of group median	+1.0
Between 90 percent and 100 percent of group median	+0.5
Between 100 percent and 115 percent of group median	——
Between 115 percent and 130 percent of group median	−1.0
Greater than 130 percent of group median	−2.0

Rationale.—The Congress has demonstrated its desire to reward efficient hospitals rather than giving a uniform limit to all hospitals. Routine costs per diem relative to peer hospitals are the best available measure of efficiency. As better measures are developed, they will be used.[1]

2. Adjustments and exceptions to the basic limit

Admissions adjustment.—Under regulations, increases in total revenues would be limited to the additional costs resulting from any increase in admissions.

Base year adjustment.—The hospital's mandatory limit in 1980 would be adjusted downward if hospitals seek to incrase costs in 1979 in anticipation of controls in 1980.

General Exceptions.—Hospitals with unusual circumstances would be permitted, on an exception basis, to have its mandatory limit adjusted upward.

3. Sanctions

Cost Payers:

Medicare, medicaid, and most Blue Cross plans reimburse hospitals for services provided their beneficiaries not on the basis of the hospital bill but rather on the basis of cost.

Approximately 60 percent of hospital revenues come from these types of payers.

Each major cost payer would limit its interim payments during the year to the mandatory limit.

For example, if the average cost of a medicare patient in Hospital A was $2,000 in 1979, and Hospital A's mandatory limit was 8.0 percent, then medicare would pay $2,160 per medicare patient hospitalized in Hospital A in 1980.

[1] Efficiency could also be measured by a hospital's relative standing on total costs per admission. However, justifiable differences in total costs per admission among hospitals may occur because they care for different types of patients. However, data do not yet exist for classifying hospitals by type of patients cared for. And until hospitals can be grouped by the type of patients cared for, routine costs per diem are a better gauge of relative efficieency than total costs per admission. In future years, as classification methods are improved, the basis for judging efficiency will be shifted to total costs per admission.

If at the end of the year, the hospital's market basket inflation was higher than forecast, medicare would increase its payments accordingly.

Charge Payers:

Uninsured patients and patients insured by commercial insurance plans pay hospitals on the basis of charges for individual services.

Approximately 40 percent of hospital revenues come from these types of payers.

Hospitals would be required to collect no more than the mandatory limit from charge-paying patients during 1980.

For example, if the average bill of a private patient in Hospital A was $2,000 in 1979 and Hospital A's mandatory limit was 8.0 percent, then the hospital could not collect more than $2,160 per private patient hospitalized.

At the end of the year, the mandatory limit would be adjusted for actual market basket inflation. If revenues from private charge-paying patients exceeded the mandatory limit, the hospital would be required to place excess revenues in an escrow account. The hospital could draw on the escrow account in future years if its revenue from charge payers were below the mandatory limit.

If the hospital received less than the mandatory limit from charge-paying patients, it would be permitted more rapid increases in future years.

A hospital's refusal to comply with the escrow requirement would result in a Federal tax of 150 percent on the excess revenues.

4. State mandatory cost containment programs

The Secretary would have funds available to support the development and implementation of mandatory State cost containment programs.

5. Commission

A commission composed of providers, third party payers, and public members would be established to make recommendations to the Secretary on major provisions of the program and needed changes as the program develops.

II. COMPARISON OF ADMINISTRATION'S HOSPITAL COST CONTAINMENT ACT OF 1979 (S. 570) AND ALTERNATIVE APPROACH DEVELOPED IN 95TH CONGRESS BY COMMITTEE STAFF—Con.

Administration's Hospital Cost Containment Act of 1979, S. 570	Possible alternative based on proposal developed by committee staff for October 1977 cost containment hearings	Committee staff comments
Applies an annual revenue limit, effective as early as 1980, to increases in hospitals' inpatient costs and charges where certain "voluntary" tests are not met.	Applies an annual revenue limit, effective as early as April 1980, to increases in hospitals' costs and charges if the hospital industry does not succeed in its "Voluntary Effort" (to reduce increases in hospital expenditures to 11.6 percent).	A somewhat later effective date is provided so that there will be time to announce the program's limits after the calendar year in which the voluntary test is failed and before the limits are to be applied.
A. *Scope of Program* A hospital would not be covered by the proposal if it:		
1. Has been in operation less than 36 months; or	1. New hospitals are not exempted. But adjustments would be made to take account of their unique cost and utilization patterns.	1. While the unique cost and utilization patterns of new hospitals should be taken into account in setting their revenue limits, there appears to be no justification for exempting hospitals on the basis of age.
2. Had an average length of stay of 30 days or more during the previous 36 months; or	2. No provision. However, limits for a long-stay hospital would be based on a comparison with comparable hospitals.	2. While the unique cost and utilization patterns of long-stay hospitals should be taken into account, there appears to be no justification for excluding them.

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3. Is a Federal hospital; or	3. Same as S. 570.	
4. Derived 75 percent or more of its revenue from HMO's during the previous 12 months; or	4. No provision.	4. There appears to be no justification for exempting hospitals on the basis of the source of their patients.
5. Is located in a nonmetropolitan area and had annual admissions of 4,000 or less during the preceding 36 months; or	5. No provision. Limits for a small nonmetropolitan hospital will be based on a comparison with similar hospitals. Limits will be adjusted for underutilization of hospitals in underserved areas regardless of whether they are urban or rural.	5. There appears to be no justification for exempting small rural hospitals, although adjustments should be made for low utilization if the hospital is needed to serve an underserved area.
6. Is participating in an approved reimbursement demonstration or experiment.	6. Same as S. 570.	
The program would not place limits on increases in expenditures due to wage increases to nonsupervisory employees.	Wages in excess of the prevailing levels would be disregarded only in the programs first year. Thereafter, limits are related to the wage levels prevailing in the hospital's area for similar work outside hospitals.	There appears to be no justification for the disregard of wage increases to levels above those paid for similar work in a hospital's area. However, disregard of excess wage levels in the first year of the program can be rationalized on the

		grounds that it eases the hospital's transition to the proposed cost controls.
The Secretary could exempt a State from the mandatory program if he: (a) determines that the State had a mandatory hospital cost containment program applicable to all hospitals and all inpatient revenues or expenses; (b) determines that the State's hospitals did not exceed the State voluntary limit by more than one percentage point in the preceding year; (c) receiving satisfactory assurances that the average rate of increase in expenses would not exceed the State voluntary limit; (d) received assurances that there was equitable treatment of all third-party payors, employees, and patients; and (e) meets other requirements established by the Secretary.	The Secretary could exempt a State which has a revenue control program which applies to all payors and to the same hospitals and revenues and expenses as the Federal program; the State must demonstrate to the satisfaction of the Secretary that, using the State's program, total retainable revenues for hospitals would not exceed those under the national program. If a State exceeds the Federal limit over a 2-year period, the Federal program would apply beginning with the following year and the excess would be carried forward to reduce the State's limit in one or more of the following years. The reduction could not exceed one percent for any year.	The staff approach does not entail Federal review and regulation of State programs so long as they apply limits that are as effective as the Federal program would have been. The language specifying that "the State must meet such other conditions as the Secretary finds equitable," is too broad and nonspecific, creating an implicit potential for unreasonableness and uncertainty.
B. *Voluntary Limit* A hospital would be subject to the mandatory Federal limits after the National and State voluntary limit has been exceeded and the individual hospital has exceeded its voluntary limit (not necessarily in the same	A hospital would be subject to the mandatory limits only after the health industry's "Voluntary Effort" has failed.	During the last Congress there was a general understanding that the voluntary test of 1978 and 1979 would be the goals established by the hospital industry's "Voluntary Effort." The 1978 goal was met. For

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year). The National voluntary limit for any year would be based on: 1. National increases in that year in the prices of appropriate classes of goods and services; plus 2. The National increase in population; plus 3. One percent (to permit an increase in service intensity). The voluntary limit for the State and individual hospital would be calculated in the same manner, but the increase in the population of the State (rather than the Nation) would be used.		1979, the goal is an increase of 11.6 percent or less in national hospital expenditures. We believe it is unfair to substitute a new test (estimated by the Administration to be about a 10 percent aggregate increase in expenditures) at this late date. The test of overall compliance by an individual hospital should be based upon a two-year moving average so as to smooth out the variations which may occur from year to year.
C. *Mandatory Limit* 1. The mandatory limit would be applied to increases in the charges and costs per admission. The basic limit would permit these costs and charges to rise from year to year by a percentage sufficient to pay only the increases in the prices of appropriate	1. Initially, two revenue limits would be calculated, one for the hospital's routine services (bed, board, routine nursing and supplies, etc.) and one for its ancillary services (X-rays, laboratory tests, drugs, etc.). If a given hospital's revenue ex-	1. A major difference between the limits under S. 570 and the staff approach is in the allowance for changes in the intensity of care, which has long been a significant factor in increases in hospital costs. Under S. 570, a bonus or penalty,

goods and services (plus whatever wage increases for nonsupervisory workers which the hospital agreed to).

If HEW's beginning-of-the-year estimates of expected price rises are too low, the limit would be revised upward at the end of the year.

For the first year a hospital is subject to the mandatory limit, it could incur a penalty equal to one-half of any percentage by which is exceeded its "voluntary" limit in the preceding year plus an additional penalty if the rate of increase in expenses accelerated in previous years.

The sum of the penalties could not exceed one-half of the percentage increase permitted by the hospital's basic limit. Any unused portion of the penalty could be carried forward.

Appropriate reductions would be made in the charges (and reimbursement) for the base accounting period (on which all subsequent limits are based) if a hospital discontinues services.

ceeded only one of the two limits, the excess revenues could be reduced to the extent they fell below the other limit.

Routine Service Revenue Limits.—Requires the comparison of routine service costs of comparable hospitals. Hospitals would be grouped according to size, type, urban or rural location and other criteria. The limit would not apply to revenues attributable to capital-related costs; costs of education and training programs; costs of interns, residents and physicians' medical services, energy costs unique to proprietary institutions; and malpractice insurance costs.

In the program's first year, the limit for a hospital would be equal to 115 percent of the average for the hospitals in its group. The portion of a hospital's revenue limit attributable to wages would be adjusted if the hospital were located in an area where general wage levels were higher or lower than the average for the hospitals in its group. For the second and subsequent years of the program, the routine service limit (as adjusted to eliminate from the average one-half of any ranging from plus 1 percent to minus 2 percent, which would impact on a hospital's spending for "intensity" would be based on the level of the hospital's routine costs relative to comparable hospitals. Additional bonus or penalty percentage points would be awarded by the Secretary as he may find is warranted. Thus, growth and development funds would be left to the discretion of the Secretary to a large extent.

Under the staff approach, after an initial transitional period, hospital costs and charges would be allowed to rise at the rate established by actual hospital experience. There would be no arbitrary limit on growth and development except for hospitals whose costs are excessive as compared to other hospitals.

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	revenues that had been disallowed in the previous year). As in the first year, adjustment would be made for any area wage differential.	
	Initial Ancillary Services Revenue Limits.—Would apply to revenues not covered under the routine service revenue limits. When the state-of-the-art permits, ancillary service revenue limits would be established in the same manner as the routine service limits—i.e., on the basis of revenues required by comparable hospitals. If the mandatory program goes into effect before the required methodology is developed, a hospital's ancillary service revenues per stay would be allowed to increase from year to year to take account of changes in general earnings levels in the hospital's locality and national	

changes in a weighted index of prices which hospitals pay for a market basket of key items and supplies reasonably representative of ancillary departments' purchasing patterns and overall costs.

2. *Efficiency Adjustment.*—The Secretary would develop a system for grouping hospitals, based on such characteristics as patient case mix and metropolitan or nonmetropolitan setting. He would also develop a method to measure relative efficiency of hospitals in each group, using a group norm based on all or certain hospital expenses (adjusted for area wage differences). He would then add to each hospital's basic limit a percentage bonus (or penalty) depending on the relationship of the hospital's expenses to the group norm, as follows:

Less than 90 percent of norm—1 percent bonus.

90 percent to 99 percent of the norm—½ percent bonus.

100 percent to 115 percent of norm—0.

116 percent to 130 percent of norm—1 percent penalty.

More than 130 percent of norm—2 percent penalty.

2. *Efficiency Adjustment.*—The allowable percentage increase in ancillary revenues would be further increased for hospitals whose routine costs were equal to or less than average for their group in the prior year. This increase would equal, in the aggregate, 25 percent of the total allowable increase in ancillary costs for the year. It would be distributed among the hospitals so that the payments to hospitals whose routine costs are 90 percent or less of their group's average would receive the largest (i.e., the highest percentage of their ancillary service costs) and the hospitals with relatively higher routine costs receiving a progressively smaller payment.

Combined limit.—The ancillary service cost limit would be combined with the routine service cost limit into a single overall limit on allowable increases in charges and costs per stay.

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3. *Other Adjustments.*—The Secretary could make further additions to (or subtractions from) the percentage limit for a hospital to take account of changes in hospital admissions, or of such other factors as he found warranted special consideration. He could make such adjustments on his own motion, or on request of a hospital. For the first year a hospital is subject to the mandatory limit, it could incur a penalty equal to one-half of any percentage by which it exceeded its voluntary limit in the preceding year plus an additional penalty if the rate of increase in expenses accelerated in previous years. The sum of the penalties could not exceed one-half of the precentage increase permitted by the hospital's basic limit. Any unused portion of the penalty could be carried forward.	3. *Other Adjustments.*—An adjustment would be made to take account of the marginal costs or savings attributable to changes in admissions volume. The size of the adjustment would be varied to take account of the individual hospital's occupancy level. In the first year of the impact of the occupancy rates would be estimated based on national data for hospitals of various bed sizes. In subsequent years the impact would be based on surveys which would provide a more direct measurement of the effects of both occupancy and other factors, or the changes in hospitals' marginal costs that result from changes in admissions volume. Adjustments could also be made, as noted above, for hospitals which demonstrate that their costs ex-	If the Secretary were to determine marginal costs for increased admissions, as was proposed in the last Administration bill, it would lead to arbitrary and inequitable results. We would suggest that no adjustments for marginal costs per admission be authorized until such time as actual sample surveys have been conducted.

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Appropriate reductions would be made in the charges (and reimbursement) for the base accounting period (on which all subsequent limits are based) if a hospital discontinues services. This reduction would be waived if the appropriate State health planning and development agency (SHPDA) determined that the services should be discontinued.

ceed their rates because of: (1) unusually high standby costs necessary to meet the needs of an underserved area; (2) atypical cost and revenue patterns of newly opened hospitals; (3) increases or decreases in services for such reasons as consolidation, sharing and approved addition of services among hospitals; and (4) evidence which demonstrates that they paid their employees larger wage increases than those received by other workers in the area because the hospital employees' wages were below the level prevailing locally for comparable or reasonably comparable work. Also, in the first year only, an exception would be made where a hospital can demonstrate that the wages paid to its employees are significantly higher (in relation to the wage level prevailing in its area) than other hospitals in its group.

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D. *Sunset Provision* There is no termination date for the program.	Would terminate at the end of 1984 unless extended by the Congress.	A requirement that Congress approve the operation of the program beyond 5 years would assure careful and thorough review of its impact on health costs and services within a reasonable period.
E. *Sanctions* Each private cost payor and each hospital would be subject to an excise tax equal to 150 percent of the amount of reimbursement from the cost payor in excess of the mandatory limit. Each hospital would also be subject to an excise tax equal to 150 percent of the excess charges not attributable to cost payors. The hospital could avoid the penalty taxes by placing the excess charges in an escrow account. In future years, it could withdraw the funds placed in the account if it reduced its charges sufficiently.	The staff suggested a similar penalty provision, but without a tax for third parties that overpay.	

F. *Improper Changes in Admissions Practices* The Secretary would be permitted to exclude a hospital from the Medicare, Medicaid or Maternal and Child Health Programs if the hospital changes its admission practices so as to reduce its proportion of patients who pay amounts (or for whom amounts are paid) that are less than the hospital's inpatient charges.	A hospital which has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient services, or that provides an unusually large proportion of routine nursing service through private-duty nurses could not receive an incentive bonus with respect to its ancillary services nor qualify for incentive payments under Medicare or Medicaid.	These somewhat similar provisions are both designed to prevent changes in hospital practices that increase reimbursement without achieving gains in the overall efficiency of the hospital system. It appears that given the nature of the offense, the penalty proposed by S. 570 seems too severe, and it is unlikely that it would ever be imposed.
G. *Effect on Public Programs* Medicare reimbursement could not exceed applicable mandatory limits established under the bill or under an approved State cost control program. No Federal matching would be available under Medicaid or the Maternal and Child Health program for any excess payments.	The staff suggests a similar provision. In addition, however, Medicare-Medicaid would make incentive payments to hospitals in accordance with the Medicare-Medicaid reimbursement reform proposal contained in Section 2 of S. 505.	
H. *National Commission* The Secretary would establish a National Commission on Hospital Cost Containment composed of 5 hospital representatives, 5 representatives of third party payors, and 5 individuals who are neither representatives of hospitals or third parties.	Proposed a similar Health Facilities Cost Commission but with a requirement that members be expert in the health facilities reimbursement area. The Commission would have the general responsibilities outlined in S. 570 and would be	

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The Commission would advise, consult with and make recommendations to, the Secretary with respect to: 1. The implementation of the cost control program; 2. Proposed modifications to its provisions; and 3. Any other matters that may affect hospital expenses or revenues.	directed to review specific areas, and to make recommendations for program changes as follows: 1. Adapting the program to include outpatient hospital costs; 2. A refined method of adjusting the revenue limits to take account of changes in marginal costs or savings attributable to changes in admissions volume and other factors; 3. The desirability of waiving applicability of the Federal reimbursement limits in the case of hospital clusters; 4. The equity, cost and efficiency of applying the various adjustments provided by the bill, and improved means of timely determination of requests for adjustments; and 5. Refinement of classifications, cost comparisons and procedures for updating cost information.	

III. ALTERNATIVE APPROACH TOWARD MODERATING HOSPITAL COSTS AND CHARGES THROUGH VOLUNTARY ARRANGEMENT WITH PRIVATE PAYERS

Concern has been expressed over the possibility that hospitals will shift costs which are disallowed under the medicare-medicaid reimbursement formula proposed under S. 505 to other payors. This possibility is of particular concern to organizations that pay hospitals on a charges basis (e.g., Prudential, Metropolitan and other commercial health insurance companies) since, ordinarily, they have no way of knowing the actual cost of the services they pay for.

The Committee may wish to consider (as an alternative to the regulatory approach) two possible approaches, depending upon whether the voluntary effort succeeds or fails.

1. Assuming the success of the voluntary effort as propounded by the health care industry, medicare-medicaid would initially establish payment limits and provide incentive payments based only upon hospitals' routine costs. Subsequently, as the state of the art develops, ancillary costs, such as X-ray, laboratory, pharmacy, etc., would be brought into the system. When a substantial portion of the costs that are covered by medicare-medicaid are subject to incentives and penalties (and thus the risk that hospitals will shift disallowed costs to charge paying third parties becomes substantial) commercial health insurers could elect to be protected against shifting through constraints on allowable increases in hospital charges.

It will be recalled that, under the medicare-medicaid system proposed in S. 505, the allowable rate of increase in costs for a given hospital is related to that hospital's costs relative to similar hospitals. For example, medicare-medicaid reimbursement for a given hospital with average costs, might be allowed to increase 12 percent while a hospital with costs significantly above the average costs in similar hospitals might be allowed a 6-percent increase in costs. Under the antishifting proposal, hospitals would not be permitted to incerase their charges for patients covered by insurers that elect to participate (and self-pay patients) by more than the lesser of the percentage increase allowed in medicare cost or the ratio of charges to costs of the group.

This would protect the many millions of people who are insured by private health insurance from the added premiums that might otherwise have to be paid to finance any excessive and unjustified increases in hospital charges.

Non-governmental costs payers, such as Blue Cross, could also voluntarily opt for the program; in such cases, the rate of increase in Blue Cross reimbursable costs could not exceed the percentage increase in medicare.

2. Under the staff alternative to the administration cost containment proposal ("9% Cap") of the last Congress, an interim mechanism for limiting increases in hospital ancillary costs was developed for use in the event the voluntary effort failed before the Health Facilities Cost Commission had developed appropriate limitations based upon comparison of hospitals' ancillary costs. In this situation, if the voluntary effort failed, private health insurers and self-pay patients could be protected by automatically providing that hospital charges could not be increased by more than the allowable percentage rate of increases in medicare costs under the interim approach.

Both of the above alternatives could be enforced through use of the tax laws.

IV. PROVISIONS OF S. 505—MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979, NOT ACTED ON BY THE COMMITTEE IN ITS MARCH 22, 1979 SESSION

Section 2. Criteria for Determining Reasonable Cost of Hospital Services

Background

The rapid growth in the costs of hospital care has focused increasing attention on hospitals and the methods currently used to reimburse hospitals. Cost-based reimbursement such as that utilized by medicare and medicaid, in particular, has been widely criticized as inflationary. There is little in the way of pressure on hospitals so paid to contain their costs, since, generally, any increases are simply passed along to the third party payors. The present "reasonable costs" procedures under the medicare program are not only inherently inflationary—because there are no effective limits on what costs will be recognized as reasonable—but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

Summary

The bill modifies the method of reimbursement for hospitals under the medicare and medicaid programs. Under the new method, to be effective with hospital reporting periods that begin after June 30, 1980, reimbursement for most of a hospital's inpatient routine costs (essentially costs other than such ancillary expenses as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals.

This initial system, described more fully below, would be studied and extended on an as-ready basis. Based on recommendations of a proposed Health Facilities Costs Commission, a permanent system would be developed over time which would establish payment rates and provide incentive payments with respect to all hospital costs and to costs of other institutions and organizations which are reimbursed on a cost basis. Continuing efforts would be made by the Commission to refine and improve the system of classification and comparison so as to achieve the greatest equity possible.

The Secretary would appoint the members of the new Health Facilities Costs Commission on or before January 1, 1980. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. At least three of the members would be representatives of hospitals and at least eight would be representatives of public (Federal, State and local) health benefits programs.

The method of reimbursement established by the bill for routine hospital costs would be as follows. Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria established by the Secretary; and

2. Comparing the routine costs (as defined for purposes of applying the medicare routine cost limits under present law) of the hospitals in each group, except for the following routine variable costs: capital and related costs; costs of education and training programs; costs of interns, residents, and nonadministrative physicians; energy costs; and malpractice insurance costs.

When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size.

A per diem target rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost for each group of hospitals under the classification system (excluded would be newly-opened hospitals and hospitals which have significant cost differentials because they do not meet standards and conditions of participation as providers of services); and

2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of the group's average per diem routine costs for area wage differentials. In the first year of the program only, an adjustment would be allowed where the hospital can demonstrate that the wages paid to its employees are significantly higher than the wages other employees in the area are paid for reasonably comparable work (as compared to the ratio for other hospitals in the same group and their areas).

The Secretary would adjust the per diem target rates by adding an annual projected percentage increase in the cost of routine goods and services hospitals purchase, with an adjustment for actual changes at the end of a hospital's accounting year.

Hospitals whose actual routine operating costs fell below their target rate would receive one-half of the difference between their costs and their target rate, with the bonus payment limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their target rate would have their reimbursement limited to 115 percent of the target rate.

In the second and subsequent years of the program, the hospital's maximum payment rate would be increased by the actual dollar increase in the average target rate for its group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

Adjustments to a hospital's target rate would be made for changes in the hospital's classification. Hospitals which manipulate their patient mix or patient flow, reduce services, or have a large proportion of routine nursing services provided by private-duty nurses would also be subject to an adjustment. Also, a hospital would qualify for any higher target rate that is applicable to the hospitals placed in the bed-size category which contains hospitals closest in bed-size to its actual bed-size.

Adjustments would be made to the target rates of hospitals which demonstrate that their costs exceed their rates because of (1) low utilization justified by unusually high standby costs necessary to meet

the needs of underserved areas; (2) atypical cost patterns of newly opened hospitals; (3) services changed for such reasons as consolidation, sharing, and approved addition of services among hospitals (e.g., costs associated with low utilization of a new wing); and (4) greater intensity of patient care than other hospitals in the same category. Some hospitals have consistently shorter lengths-of-stay in treating patients than their group average for a reasonably similar mix of patients with comparable diagnoses. To the extent that a hospital can demonstrate that the shorter stays result from an "intensity" of service which makes it necessary for the hospital to incur additional costs, such additional costs per day, to the extent reasonable, would be recognized under the "intensity" exception provision.

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has a generally applicable hospital reimbursement control system which applies at least to the same hospitals and kinds of costs as are subject to the new reimbursement reform system; and (b) the State demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursable costs for hospitals in the State will be no greater than if the Federal system had been applicable. A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs for any two-year period would be covered under the Federal limits beginning with the subsequent year. The amount of the excessive payments would be recouped over subsequent periods through appropriate reduction (not in excess of one percent annually) in the cost limits otherwise applicable.

States which obtain a waiver would be reimbursed for the medicare program's proportionate share of the cost of operating the State reimbursement control system. The State's medicaid program would pay its proportionate share of costs, which would be matchable with Federal funds as an administrative expense.

Medicare and medicaid would also pay a proportionate share of startup costs of approved State reimbursement control systems. The Federal share of the startup costs would be the same proportion as the Federal payment for inpatient hospital costs in the State bears to the total inpatient hospital costs which are subject to the State system. For example, if the Federal Government pays, through medicare and medicaid, 40 percent of the total hospital costs in the State that are subject to the State system, it would be liable for 40 percent of the State program's startup costs.

Staff recommendation: To ease transition of the proposed reimbursement system, provide that only one-half of the incentives and penalties be applied during the first two years.

POSSIBLE MODIFICATION FOR ADDITIONAL COST SAVING

Background

Section 2 of the bill would moderate increases in reimbursement for hospital routine costs under medicare and medicaid. The proposed reimbursement reform was not made immediately applicable to hospitals' ancillary costs (X-ray, laboratory, pharmacy, etc.) because no methodology has yet been developed for equitable inter-hospital comparisons of ancillary service costs. Thus, insofar as ancillary costs are

concerned, there would be no protection for medicare and medicaid if the hospital industry's voluntary cost containment effort should fail and ancillary costs were to increase excessively.

Modification

Establish limits, effective April 1, 1980, on allowable increases in medicare and medicaid reimbursement for ancillary services if the hospital industry's cost containment goal (an increase not to exceed 11.6 percent) is not met in 1979. The maximum increase permitted for medicare-medicaid reimbursement purposes would be related to increases in the cost of goods that hospitals purchase in order to produce ancillary services and would take account of area wage level differentials. The limits would be recalculated annually until the reimbursement methodology prescribed in the bill could be implemented.

Cost Estimate:

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Medicare	0	−15	−45	−120	−225
Medicaid	0	−5	−25	−40	−65
Possible modification	−250	−1,000	−1,900	−2,800	−4,100

Section 6. Hospital Associated Physicians

Background

Many physicians in the fields of radiology, anesthesiology, and pathology generally engage in a variety of professional activities including teaching, research, administration, and other hospital activities in addition to furnishing or supervising medical services for individual patients.

Under present law, a variety of payment mechanisms are recognized for reimbursement purposes. One form involves an arrangement between physicians and the hospitals under which the physicians' compensation is based on a percentage of departmental gross charges or of net collections. These percentage arrangements generate substantially higher costs to medicare and medicaid than other forms of compensation, which are more directly related to personally rendered professional time and effort.

Summary

The bill preserves the eligibility of radiologists, pathologists and anesthesiologists to be paid by medicare and medicaid on a fee-for-service basis for patient care services which they personally perform or personally direct. Services which the physician may perform for the hospital as an executive, educator or supervisor would be reimbursed only through the hospital insurance program on a reasonable cost basis. Percentage or lease arrangements would ordinarily not be recognized for medicare and medicaid reimbursement purposes to the extent they exceed what would have been paid to an employed phy-

sician. These provisions were developed with the help of representatives of the American College of Radiology and the American Society of Anesthesiologists. This section will avoid excessive payment to some physicians for services which they do not personally provide.

The provision in present law which permits 100-percent payment for inpatient radiology and pathology tests, instead of 80 percent as is the case with all other physician services under medicare, would be restricted to physicians who agree to become "participating physicians."

Staff Recommendation

Delete provision and amend Section 19 by adding a new paragraph (3) at the bottom of page 69 of the bill stating that Medicare and Medicaid would not recognize, for purposes of reimbursement:

"a charge (as distinguished from compensation based primarily on the time personally spent by a physician in performing the services for which the compensation is paid) which is attributable to a physician's supervisory, executive, educational or research activity in a hospital and which does not represent a service that: (a) is personally performed or personally directed by such physician for the exclusive benefit of a patient: and (b) is of such a nature that its performance by a physician is customary and appropriate."

The Committee requested the staff to see whether an approach might be developed whereby the intent of Section 6 could be achieved by modification of Section 19.

The staff developed the above language for Section 19 which it believes would avoid excessive reimbursement and permit the deletion of Section 6.

This approach would preclude Medicare-Medicaid recognition of billing arrangements unrelated to the time and effort expended by a physician. It would, however, *not* affect the definition of "pathology" or "*physicians' services*".

The change is responsive to the concern expressed by the American Medical Association in its testimony on Section 6 relative to possible confusion concerning the definition of a physician's service.

The suggested change does not affect the ability of a physician to charge fees for services to a patient which he personally renders or personally directs for that patient. Also, the suggested language provides for reimbursement to be made, as under present law, for a physician who is compensated by a hospital on a per-session or other time-related basis for supervisory and administrative responsibilities with respect to the operation of one of the hospital's departments.

Cost Estimate:

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Medicare	−48.0	−52.8	−58.1	−63.9	−70.3
Medicaid	−7.0	−7.7	−8.5	−9.3	−10.2

Section 10. Criteria for Determining Reasonable Charge for Physicians' Services

Background

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. This has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, all prevailing charges are annually adjusted upward to reflect changes in the costs of practice and wage levels. The effect of present law is to further widen the dollar gap between prevailing charges in different localities.

Summary

The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Background

Under existing law, medicare allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality.

Summary

The bill would permit new physicians in localities, designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual fee levels.

Cost Estimate:

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Medicare	−2.0	−4.0	−4.4	−4.8	−5.3

Section 14. Reimbursement Rates Under Medicaid for Skilled Nursing Facilities and Intermediate Care Facilities

Background

Present law requires States participating in medicaid to pay skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) on a reasonable cost-related basis. This requirement, added by section 249 of the Social Security Amendments of 1972, gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

There has been considerable controversy over whether the reimbursement mechanisms developed under section 249 may include an allowance in the form of incentive payments related to efficient performances by providers. There was no intent, in enacting section 249, to preclude such allowances if they are related to efficient provider performance.

Summary

The bill allows States the option, when computing reimbursement rates under medicaid to a SNF or ICF, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

Note: This section presupposes continuation of Sec. 249. If that section were repealed, this provision would be unnecessary.

Cost Estimate:

Negligible costs or savings.

Section 19. Procedure for Determining Reasonable Cost and Reasonable Charge

Background

Some hospitals and other organizations that are reimbursed by medicare and medicaid deal with contractors, employees or related organizations, consultants, or subcontractors who are paid (in whole or in part, in cash or kind) on the basis of percentage arrangements.

Such arrangements can take several forms. For example, some involve business contracts for such support services as computer and data processing, financial and management consulting, or the furnishing of equipment and supplies to providers of health services, such as hospitals. Charges for such services are subsequently incorporated into the cost base against which medicare and medicaid make their payment determinations.

The contracts for these support services specify that the remuneration to the suppliers of the services shall be based on a percentage of the gross or net billings of the health care facilities or of individual departments. Other examples involve landlords receiving a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the programs which may not reflect actual efforts expended or costs incurred.

Summary

The bill provides, except under certain specified circumstances, that reimbursement to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized where compensation or payments (in whole or part, in cash or kind) as based upon percentage arrangements.

The prohibition against percentage arrangements contained in this section of the bill would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis. It would also apply to management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization, or from the original provider or organization to the supplier or service agency.

There is no intent, however, to interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the commission paid to a salesman. Further, the bill does not prohibit reimbursement for certain percentage arrangements such as a facility management contract where the arrangement contributes to efficient and economical operation.

For example, under some existing management contracts, the contractor receives both a percentage of operating expenses as a base management fee, and a share of the net revenues of the institution after all costs have been met. Where the contractor's percentage share of net revenues exceeds the percentage on which the base management fee is calculated, the contractor could have a strong incentive to con-

tain operating expenses. Of course, under such circumstances, the reasonableness of the percentages applicable to the operating expenses would have to be considered in terms of comparison with the costs incurred in the management and/or operation of reasonably comparable facilities which do not utilize such contracts.

Cost Estimate:
Not available.

Section 25. Rate of Return on Net Equity for For-Profit Hospitals

Background

Under present law, the medicare program allows for-profit hospitals a return on equity capital invested and used in providing patient care. The amount allowable is determined by applying to the proprietary hospitals equity capital one and one-half times the rate of return earned on social security trust funds. This formula produced a rate of return of 12.6 percent in October 1978. Profitmaking hospitals argue that this return compares unfavorably to that of comparable businesses.

Summary

The bill changes the allowed rate of return on for-profit hospitals' net equity. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in section 2 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits. The new rates of return, payable at the time of the hospital's final cost settlement would become effective at the same time as the new incentive reimbursement system—i.e., hospital accounting periods beginning on or after July 1, 1980.

Cost Estimate:

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Medicare	20.0	48.0	58.0	69.0	83.0

Section 30. Payment for Durable Medical Equipment

Background

Under the medicare law, reimbursement for the rental or purchase of durable medical equipment is based largely on the supplier's customary charge for the item and on the prevailing charge for the equipment in the locality. Medicare has experienced problems with this method of reimbursement because of the lack of uniformity in suppliers' billing and charging practices; differences in the level of services offered by different suppliers; the different approaches medicare carriers follow in calculating allowances for medical equipment; and because equipment charges are not set in broadly competitive marketplace.

Summary

The bill establishes a new reimbursement methodology for medical equipment intended to correct these problems. Under the new method, reasonable charges for durable medical equipment would be calculated on a prospective basis and would take into account, in addition to the customary charges, the acquisition costs of the equipment, appropriate overhead (considering the level of delivery services and other necessary services provided by the supplier), and a reasonable margin of profit.

Background

An additional problem has arisen as a result of the provision of present law which authorizes lump-sum payments by medicare for durable medical equipment where purchase would be more economical than rental. In these cases the patient is responsible for paying (in addition to any deductible and coinsurance amounts) any difference between the supplier's charge for the item and the medicare allowable charge. This difference can be substantial since the medicare allowable charge is based on charge levels as they existed from 12 to 24 months in the past.

Summary

The bill would eliminate this lag where the medicare allowable charge is calculated in full accordance with the new methodology by permitting the allowable charges to be calculated (no less often than annually) on a prospective basis.

Cost Estimate:

Not available.

Section 33. Encouragement of Philanthropic Support for Health Care

Background

Under present medicare policy, in determining the reasonable costs of services furnished by a provider of health services, unrestricted grants, gifts and income from endowments are not deducted from reimbursable costs of the provider.

Summary

The bill provides a statutory base for this policy.

Cost Estimate:

No cost impact.

Section 34. Study of Availability and Need for Skilled Nursing Facility Services Under Medicare and Medicaid

Background

Under current law, skilled nursing facilities (SNFs) participating in one of the programs are not required to participate in the other. In some States, there are a larger number of medicaid-only participating SNFs and in other States, the reverse is true. If a greater number of SNFs could be prompted to participate in both programs, a more adequate number of skilled nursing facilities would be available for medicare and medicaid beneficiaries.

Summary

The bill directs the Secretary of HEW to conduct a study of the availability and need for skilled nursing facility services under the Medicare and Medicaid programs. The study would consider the desirability of requiring facilities that wish to participate in one program to participate in both. The study would also investigate possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing services.

In developing the study, the Secretary would consult with professional organizations, health experts, private insurers, nursing home providers and consumers of skilled nursing facility services. A report on the Secretary's findings and recommendations would be due 6 months after the date of enactment.

Cost Estimate:

Two hundred thousand dollars in fiscal year 1980; no cost impact thereafter.

Section 35. Coverage Under Medicare of Certain Dentist's (Section 5 of S. 507)

Background

Under present law, medicare covers the services of dentists when they are performed by a licensed doctor of dental or oral surgery only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone. The law, therefore, excludes from coverage certain nonsurgical procedures which dentists and oral surgeons are professionally trained and licensed to perform even though the same services are covered when performed by a physician.

Summary

The bill extends the coverage of dental services under medicare to include any services performed by a doctor of dentistry or of dental or oral surgery which he is legally authorized to perform in cases where the services would be covered if performed by a physician.

Cost Estimate:

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Medicare	12.5	14.5	16.5	19.0	22.0

V. ADDITIONAL STAFF ALTERNATIVES FOR POSSIBLE COST SAVINGS PROPOSALS

1. Reimbursement for Outpatient Hospital Care

Background

As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have the patients using their outpatient departments meet a disproportionately large share of the hospitals' total costs.

Possible alternative

To prevent medicare and medicaid from bearing grossly excessive outpatient hospital costs, Medicare reimbursement for these costs and related physician charges could be limited to an amount not greater than double the prevailing charges the program would have paid had the services been furnished in a private physician's office.

Background

In addition, reimbursement to community health centers and other freestanding clinics which are presently paid on a cost-related basis have sometimes proved to be excessive.

Possible alternative

A provision could be adopted under which the clinics in question (other than the recently covered rural clinics) could not be paid more than the prevailing charge that would have been paid for the services had they been furnished in an independent practitioner's office.

Note: Application of the limits could be made based upon a reasonable and adequate sample of patient records of conditions treated, services and charges in each hospital outpatient department. Separate charges would not ordinarily be recognized for services which are ordinarily commonly grouped and a single charge made. Only one visit would be reimbursable for services ordinarily provided during a single visit.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−50	−50	−50	−50	−50

2. Disproportionate Medicare-Medicaid Payments for Hospital Care

Under present policy, medicare reimburses hospitals for a disproportionately large share of the costs of routine nursing even though there is no objective, convincing evidence that this "plus factor" is warranted. On the other hand, medicare and medicaid are called on to pay a full share of hospitals' malpractice insurance costs even though reliable studies show that the elderly and the poor account for a relatively small portion of the malpractice insurance awards. (The Finance Committee staff previously suggested, along with other staff suggestions submitted to HEW at the Committee's direction, but without

the Committee's formal endorsement, that HEW policy should be modified to provide for an appropriate adjustment to be made to more realistically reflect medicare's share of malpractice insurance costs; the President's Budget includes this proposal and projects savings in fiscal year 1980 of $310 million.)

Possible alternative

No routine nursing plus factor nor any other plus factor would be paid until such time as evidence can be produced which, in the judgment of the Comptroller General, concurred in by the Secretary of HEW, justifies a specific plus factor as warranted under given circumstances for given facilities.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−223	−223	−223	−223	−223

3. Prohibit Medicare-Medicaid Payment at Hospital Rates for Patients Medically Determined to Need Lesser Levels of Care

Professional Standards Review Organizations (PSROs) have found thousands of medicare and medicaid patients being kept in costly acute-care hospital beds instead of being appropriately placed in nursing facilities or detoxification units.

The situation occurs most frequently in those areas where there is a surplus of hospital beds and a shortage of long-term care beds.

Possible alternatives

(a) Authorize a program of grants and loans to facilitate conversion to long-term care beds of surplus acute hospital beds in public and non-profit hospitals. Priority would be given to high cost urban areas. Priority would be given to complete conversion of a hospital to long-term care as opposed to partial changeover. (b) Effective not later than April 1, 1980, medicare and medicaid payments to hospitals would be made at the average skilled nursing facility or intermediate care facility payment rate (as may be appropriate) rather than the much higher hospital rate for patients medically determined by reviewers as not in need of acute hospital care but who are in need of a program reimbursable level of long-term care. Days of care paid by medicare at the reduced rates would be counted against the patient's eligibility for skilled nursing facility benefits and the skilled nursing facility benefit coinsurance rates would also be applicable. To prevent undue hardship, the limitation would not apply during the first day, to certain terminally ill patients nor in those geographic areas where the appropriate State or local planning agencies certify that there is no general excess of hospital beds, and there is a shortage of long-term care beds.

Where a hospital converts active acute care beds to long-term care usage under this provision, it could be permitted to reconvert those beds back to acute care usage within a period of 2 years without being subject to the sec. 1122 approval process.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−89	−92	−96	−100	−104

4. Federal Advance Payments to States

Present Federal policies permit States to draw on Federal medicaid funds before they are actually needed to pay recipients. During the period between the time when the Federal funds are drawn by the State and the time when they are disbursed to medicaid recipients, about 12 days on the average, the funds can draw interest which accrues to the State. HEW has proposed that the gap should be eliminated in fiscal year 1980 in 10 States, producing a one-time saving of $240 million for Medicaid.

Possible alternative

Extend the new "checks paid" policy to all 50 States in 1980.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−158	0	0	0	0

5. Competitive Bidding and Negotiated Rates Under Medicaid

States have been restrained from adopting cost-saving contract bidding and negotiated rate arrangements with laboratories under their medicaid programs by an interpretation of the present "freedom of choice" provision of Federal law. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, pharmacies, etc. It was not intended to apply to the types of care or services which the patient ordinarily does not choose.

Similarly, judicial interpretation of the "freedom of choice" provision has hampered cost-saving arrangements by States for the purchase under medicaid of medical devices (such as eyeglasses, hearing aids and wheelchairs) even though these items often do not vary in quality from supplier to supplier.

Possible alternative

Permit States, at their option, to provide such services and items for medicaid purposes through competitive bidding or appropriate negotiated arrangements.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−1.5	−1.6	−1.7	−1.8	−1.9

6. Direct Professional Review Toward Avoiding Unnecessary Routine Hospital Admission Services and Excessive Preoperative Stays

Present policies direct PSROs to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and on the appropriateness of the length of the stay. PSRO studies have amply demonstrated the extent to which unnecessary or avoidable utilization occurs with respect to certain hospital practices that have not been subject to general across-the-board review, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days.

Possible alternative

Direct PSROs to review these areas of relatively frequent overutilization to assure that payment is made under the public programs only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

For example, as is now the case in some PSROs, elective admissions for surgery that involves preoperative stays of more tha one day would require specific PSRO approval in order to be reimbursable. Similarly, weekend admissions for elective conditions would be reimbursable only where the PSRO finds that the hospital is equipped and staffed to provide necessary services over the weekend.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−360	−360	−360	−360	−360

7. Delete Statutory Requirement Specifying State Payment of "Reasonable Costs" to Hospitals Under Medicaid

States have complained that present Federal statutory and regulatory requirements with respect to payments for hospitalized medicaid recipients unduly constrain their administrative and fiscal discretion.

Possible alternative

Delete the present statutory requirement and allow States the discretion of determining appropriate Medicaid reimbursement to hospitals (but not in excess of the amount that would be determined to be reasonable under medicare).

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−38	−42	−46	−51	−55

8. Delete Statutory Requirement Specifying State Payment of "Reasonable-Cost-Related" Reimbursement to Skilled Nursing and Intermediate Care Facilities

States have complained that present Federal statutory and regulatory requirements with respect to medicaid patients in long-term care facilities unduly constrain their administrative and fiscal discretion.

Possible alternative

Delete the present statutory requirement and allow States the discretion of determining appropriate levels of nursing home and intermediate care reimbursement.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−51	−56	−62	−67	−74

9. Apply "Prudent Buyer" Limit to Purchases by Hospitals of Routine Supplies

Studies of hospital purchasing practices undertaken by the General Accounting Office at the request of the Subcommittee on Health of this committee have disclosed instances of costly and wasteful purchasing. The excessive and avoidable costs are being passed on to medicare, medicaid and other payers.

Possible alternative

For the most frequently purchased supplies establish maximum allowable cost limits essentially based upon the median prices at which those items may be procured in given quantities at given points in time. Costs in excess of the maximum allowable amounts would not be recognized by medicare and medicaid.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−45	−45	−45	−45	−45

10. Medicare Payment Liability Secondary Where Payment Can Also be Made Under Accident Insurance Policy

Under present law, medicare is ordinarily the payor of first resort except in certain cases, e.g., where the patient has no legal obligation to pay, or where workmen's compensation is responsible for payment for the patient's care.

Possible alternative

Where the medicare patient is involved in an accident and his care can be paid for under the insurance policy of the individual who was

at fault, medicare would have residual and not primary liability. Under this proposal, medicare would pay for the patient's care in the usual manner and then seek to be reimbursed, where the estimated recoverable amount exceeds $500, by the private insurance carrier after, and to the extent that, its liability has been determined.

Cost Estimate:

[By fiscal year, in millions of dollars]

1980	1981	1982	1983	1984
−132	−145	−159	−173	−187

11. Require Consideration of Disability Health Status in Calculating HMO Incentive Payments under Medicare

Under present law, HMO's that participate in Medicare on a risk basis receive monthly per capita payments that are based on estimates of the amounts the program would have paid had the Medicare beneficiaries received their health care outside the HMO. The law requires that, in calculating these payments, consideration be given to the "disability status" of the Medicare beneficiaries who are members. The purpose of the requirement is that the relative "healthiness" of the member must be assessed to prevent overpaying HMO's whose enrollees will need relatively little health care. (It is likely that this will be the case since beneficiaries with a substantial history of illness are likely to remain with the physician who has treated them in the past.) The thrust of this and similar requirements was to assure that an HMO's performance (and incentive payments) would be compared against a reasonably comparable population outside the HMO. The requirements are designed to avoid "windfall" profits unrelated to an HMO's performance. Nevertheless, the "health status" requirement has been interpreted by HEW as requiring only that HMO payment rates be calculated separately for the aged and for Social Security disability beneficiaries as opposed to adjusting for the relative health status of those enrolled in an HMO and those not enrolled.

Possible alternative.—Delete the reference to "disability status" and substitute a requirement that the health status of the Medicare beneficiaries should be considered.

Cost estimate.—Not available.